State of California—Health and Human Services Agency

Department of Health Services
County Medical Services Program

To: Department of Health Services
Third Party Liability
P.O. Box 2471
Sacramento, CA 95812-2471

Date: _____

Mail: Original
File: Copy

County Medical Services Program (CMSP)
POTENTIAL THIRD PARTY LIABILITY NOTIFICATION

1. Have you used, **or will you use,** CMSP for your injury or illness? ..... ❒ Yes ❒ No

2. Have you filed, **or will you file,** a lawsuit or insurance claim? ..... ❒ Yes ❒ No

*If you answered **Yes** to one or both of the above questions, complete the following:*

3. Injury/illness occurred at: ❒ Home ❒ School ❒ On someone else's property
❒ Work ❒ Motor vehicle ❒ Other _____

Case name (first, middle, last)			Date of injury or illness (*DATE MUST BE PROVIDED.*)	
Address (number, street)	City	State	ZIP code	Social Security number – –
Mailing address	City	State	ZIP code	Telephone number ( )

Injured Persons(s):

Name	Date of Birth	County Code	Aid Code	Social Security Number (If not available, CMSP or CIN)

4. Have you filed, **or will you file,** a lawsuit? ❒ Yes ❒ No If yes, please provide the following information:

Attorney name		Telephone number ( )	
Mailing address	City	State	ZIP code

5. Is there insurance (other than CMSP) **covering you or anyone else** for this injury/illness (auto, homeowners, premise liability, accident, health)? ❒ Yes ❒ No If yes, please provide the following information:

Insurance company		Telephone number ( )	
Mailing address	City	State	ZIP code
Claim adjuster	Claim/policy number	Policy holder	

WORK RELATED INJURY

Have you filed an application for Workers' Compensation benefits? ❒ Yes ❒ No

Employer at time of accident	Telephone number ( )	Workers' Compensation claim/case number
Mailing address	City	State / ZIP code

DO NOT WRITE BELOW THIS LINE

COUNTY USE ONLY

Eligibility worker	Worker number	County	Telephone number ( )